Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		B105134	B. WING		07/16/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HMONG A	DULT HOME CARE	2617 69TH KANSAS (I ST CITY, KS 66109)		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET	TE
S 000	00 INITIAL COMMENTS		S 000			
	The following citation represents the findings of a resurvey at the above named adult day care on 7-15-15 and 7-16-15.					
S2120 SS=F	S2120 SS=F 26-43-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100;(3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident 's legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident 's legal representative, the resident 's family.		S2120			
	This REQUIREMENT is not met as evidenced by: KAR 26-43-202(d)					
	sample included 3 res review and interview sampled residents, the the review and, if nec	a census of 3 residents. The sidents. Based on record for 3 (#101, #102, #103) of 3 are operator failed to ensure essary, revision of each reement at least once every				
	Findings included:					
- Record review for resident #101 revealed		esident #101 revealed				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING O7/16/20	
B WING	
B105134 B. WING 07/16/2	/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HMONG ADULT HOME CARE 2617 69TH ST KANSAS CITY, KS 66109	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
S2120 Continued From page 1 admission on 9-19-11. The Functional Capacity Screen dated 4-28-15 recorded resident required supervision with transfers; physical assistance with walking/mobility; and independent with bathing, dressing, toleling and eating. Continent of bladder. Cognition: problems with short term memory and memory/recall. Current problems/risks included unsteadiness. Uses cane. The Negotiated Service Agreement (NSA) dated 4-1-13 recorded services for Nutrition (daily) breakfast, lunch and snack) and assistance with personal hygiene. Facility to provide transportation and activities. The NSA lacked review and if necessary revision at least once every 365 days. - Record review for resident #102 revealed admission on 8-28-12. The Functional Capacity Screen dated 4-28-15 recorded resident independent with bathing, dressing, tolleting, transfers, walking/mobility and eating; supervision with management of medications/trathements. Continent of bladder. Cognition: problems with memory/recall and decision-making. Current problems/risks included falls, impaired hearing, and impaired vision. The Negotiated Service Agreement (NSA) dated 4-1-13 recorded services for Nutrition (daily) breakfast, lunch and snack). Independent with Personal Care. Facility to provide transportation and activities. The NSA lacked review and if necessary revision at least once every 365 days. - Record review for resident #103 revealed	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		B105134	B. WING		07/16/2015	<u>; </u>				
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2617 69TH ST 2617 69TH ST									
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIT DEFICIENCY)	D BE COMP	PLETE				
S2120	recorded resident ind dressing, toileting, tra eating; unable to perf medications; and sup Continent of bladder. memory/recall and de problems/risks includ The Negotiated Servi 4-1-13 recorded servi breakfast, lunch and Personal Care. Facil and activities. The N necessary revision at Interview on 7-15-15 confirmed the NSA w once every 365 days. For residents #101, # failed to ensure the residence of the support of the residents and the residents and the residents are supported to the residents and the residents are supported to the residents are supp	city Screen dated 4-30-15 ependent with bathing, nsfers, walking/mobility and orm management of ervision with treatments. Cognition: problems with ecision-making. Current ed falls. ce Screen (NSA) dated ces for Nutrition (daily snack). Independent with tty to provide transportation SA lacked review and if least once every 365 days. at 1:15 pm with operator as not reviewed at least 102, and #103, the operator eview and, if necessary, the tiated service agreement at	S2120							